san marcos treatment center

DISCLOSURE OF THIRD PARTY COVERAGE

Patient Name: _____

When filing for reimbursement with insurance or other payors for your child's treatment while at San Marcos Treatment Center, there are many rules and regulations with regard to filing primary insurance or secondary coverage.

It is imperative that the facility be informed of all medical/psychiatric third party coverage before or upon admission.

Please list all plans your child is covered under, whether it be insurance, TriCare or Medicaid.

Primary Insurance Company Name _____
Policy Holder Name/Relationship_____
Policy Holder DOB_____SS#_____
ID#_____Group#_____Phone#_____

Secondary Insurance Company Name _____
Policy Holder Name/Relationship_____
Policy Holder DOB_____SS#_____
ID#_____Group#_____Phone#_____

Tertiary Insurance Company Name _____
Policy Holder Name/Relationship_____
Policy Holder DOB_____SS#_____
ID#_____Group#_____Phone#_____

I certify that my child is covered by the above policies and that this is a complete list. I understand if I have not listed all coverages, I may be held responsible for any amounts not covered by these policies, as the facility will not have complete information.

_____ _____
Patient's Legal Representative (Signature) Patient's Legal Representative (Print Name)

_____
Date

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